DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155237		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/05/2011		
NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE	
K0000	State Licensure State Indiana State accordance with Survey Date: 04 Facility Number: Provider Number: AIM Number: 1 Surveyor: Mark Code Specialist At this Life Safet Village Nursing I compliance with Participation in MCFR Subpart 483 Fire and the 2000 Fire Protection A Life Safety Code Existing Health C410 IAC 16.2. This one story fabe of Type V (00 sprinklered. The system with smocorridors, areas in corridor and in all	000142 :: 155237	K00	00	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the fof Correction be considered the Letter of Credible Allegation up revisit on or after 04/16/2011.	ot s n of Plan e	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6CBP21

Facility ID:

000142

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED	
155237		B. WING	04/05/2011			
NAME OF B	DOWNER OF CHIRD IED			T ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			3518	S SHELBY ST		
BETHANY VILLAGE NURSING HOME			INDIANAPOLIS, IN46227			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE	
IAG		LSC IDENTIFYING INFORMATION)	TAG	DLI ICILI C I)	DATE	
		of 73 at the time of this				
	visit.					
		Robert Booher, REHS, Life list-Medical Surveyor on				
	The facility was	found not in compliance				
	· -	entioned regulatory				
	requirements as	9				
	following:					
	Terre wing.					
K0050	varying conditions shift. The staff is a and is aware that routine. Responsi conducting drills is competent person exercise leadershic conducted between	s who are qualified to ip. Where drills are en 9 PM and 6 AM a coded ay be used instead of				
SS=F		ord review and interview, the K0050		K050: NFPA Life Safety Code	01/10/2011	
	facility failed to ensure fire drills were conducted quarterly on the third shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility			Standards. Fire Drills. Fire Dri	ills	
				are held at unexpected times under varying conditions, at le	ast	
				quarterly on each shift. What		
				corrective action(s) will be		
	including residen	nts, staff and visitors.		accomplished for those reside	l l	
	Findings include	:		found to have been affected by the deficient practice? A third shift fire drill was conducted on 04/12/2011 at	ý 	
	Based on review of "Monthly Fire Drill			11:30pm. How will you identify other		
	Report" document			residents having the potentia	al	
	Maintenance Sup	pervisor from 9:40 a.m. to		to be affected by the same		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6CBP21 Facility ID: 000142

If continuation sheet

Page 2 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING 01		01	COMPLETED	
155237		B. WIN			04/05/2011		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					SHELBY ST		
DETUANNA VIII A OF NIIIDOINO LIOME					IAPOLIS, IN46227		
DETHAN	ANY VILLAGE NURSING HOME			INDIAN			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	11:15 a.m. on 04	/05/11, there is no			deficient practice and what		
	documentation of	f a fire drill being			corrective action will be		
		third shift in the first			taken?All residents have the		
				potential to be affected.			
	-	Based upon interview at			What measures will be put into		
	the time of record				place or what systemic		
	Maintenance Sup	pervisor stated the third			changes you will make to		
	shift fire drill wa	s conducted but			ensure that the deficient		
	acknowledged th	ere is no documentation			practice does not recur?		
		eport available for review.			The Maintenance Supervisor received and reviewed the		
		port available for review.			American Senior Communities	,	
	2.1.10/1-)				(ASC) fire drill staggered times		
	3.1-19(b)				guidelines and has set calenda		
					dates to ASC staggered times		
					The calendar was submitted to	l l	
					and reviewed by the Executive	·	
					Director.The Maintenance		
					Director submits the Monthly F	-ire	
					Drill Report with staff response		
					to the Safety Committee month	nly.	
					How the corrective action(s)		
					will be monitored to ensure t	·	
					deficient practice will not rec	ur,	
					i.e., what quality assurance		
					program will be put into plac	e	
					The quarterly calendar for fire drills is submitted to the Execu	tivo	
					Director prior to the end of each		
					quarter to ensure staggered	"	
					drills. Fire drills and response	es	
					are reported to the Continuous		
					Quality Improvement (CQI)		
					committee overseen by the		
					executive director. If compliar	ce	
					is not achieved then an action		
					plan may be developed to ens	ure	
					compliance.		
K0052	•	n required for life safety is					
installed, tested, and maintai							
accordance with NFPA 70 National Electrical							
					!		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155237 04/05/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3518 S SHELBY ST BETHANY VILLAGE NURSING HOME INDIANAPOLIS, IN46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 SS=F K052: NFPA Life Safety Code K0052 04/16/2011 Based on record review and interview, the Standards. A fire alarm system facility failed to ensure 2 of 11 fire drills required for life safety is installed, conducted over the past year included the tested, and maintained in transmission of a fire alarm signal to accordance with NFPA 70 National Electrical Code and protect 73 of 73 residents. NFPA 72, NFPA 72. The system has an Table 7-3.2 number 23 requires the approved maintenance and supervising station fire alarm system be testing program complying with tested monthly. This deficient practice applicable requirements of NFPA 70 and 72. What corrective could affect all residents in the facility. action(s) will be accomplished for those residents found to have Findings include: been affected by the deficient practice? A third shift fire drill was conducted on 04/12/2011 at Based on review of "Monthly Fire Drill 11:30pm with transmissions of a Report" documentation with the fire alarm signal. How will you Maintenance Supervisor from 9:40 a.m. to identify other residents having 11:15 a.m. on 04/05/11, third shift fire the potential to be affected by drills conducted on 06/19/10 at 3:15 a.m. the same deficient practice and and on 09/23/10 at 2:55 a.m. did not what corrective action will be taken? All residents have the indicate in the fire alarm test section of potential to be affected. What each report the fire alarm system was measures will be put into place activated and included a statement or what systemic changes you indicating these were silent drills. Based will make to ensure that the on an interview with the Maintenance deficient practice does not recur? The Maintenance Supervisor at the time of record review, Supervisor reviewed the when silent drills are conducted the guidelines for conducting fire drills facility does not test the fire alarm system that includes transmitting the fire during the daytime near the date when the alarm signal. The Maintenance Supervisor conducts fire drills drills are conducted to include a test of the based on the American Senior fire alarm system. Communities' (ASC) fire drill staggered times guidelines and

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	01	COMPLETED	
		155237	B. WING		04/05/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
DETLIAN	Y VILLAGE NURSII	NG HOME		SHELBY ST IAPOLIS, IN46227	
				NAPOLIS, IN40221	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K0144	3.1-19(b) Generators are ins	spected weekly and pad for 30 minutes per		has set calendar dates to ASC staggered times. All fire drills have transmission of the fire alarm signal. The calendar was submitted to and reviewed by Executive Director. The Maintenance Director submits Monthly Fire Drill Report with responses and signal transmission to the Safety Committee monthly. How the corrective action(s) will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. The quarterly calendar for fire drills is submitted to the Executive director prior to the end of each quarter to ensure staggered drills. Fire drills, responses an alarm transmission are reported to the Continuous Quality Improvement (CQI) committee overseen by the executive director. If compliance is not achieved then an action plant to be developed to ensure compliance.	as the the staff cur, e utive ch ad ed
SS=C	Based on record facility failed to opercentage for the the generator for 3-4.4.1.1 of NFP testing of generators.	review and interview, the document the load e monthly load test for 3 of 12 months. Chapter A 99 requires monthly tors serving the fical system to be in	K0144	K144: NFPA Life Safety Code Standards. Generators are inspected weekly and exercise under load for 30 minutes per month in accordance with NFPA99.What corrective action(s) will be accomplished those residents found to have been affected by the deficient	ed

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6CBP21

Facility ID:

000142

If continuation sheet

Page 5 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155237 04/05/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3518 S SHELBY ST BETHANY VILLAGE NURSING HOME INDIANAPOLIS, IN46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE accordance with NFPA 110. Chapter practice? A 30-minute generator load test 6-4.2 of NFPA 110 requires generator sets was conducted 04/15/22 at in Level 1 and Level 2 service to be 2:00pm with the percentage of exercised at least once monthly, for a load capacity and minimum exhaust gas temperature minimum of 30 minutes, using one of the documented. following methods: How will you identify other a. Under operating temperature conditions residents having the potential or at not less than 30 percent of the EPS to be affected by the same (Emergency Power Supply) nameplate deficient practice and what corrective action will be rating. taken? All residents have the b. Loading that maintains the minimum potential to be affected. exhaust gas temperatures as What measures will be put into recommended by the manufacturer. place or what systemic The date and time of day for required changes you will make to ensure that the deficient testing shall be decided by the owner, practice does not recur? based on facility operations. This The Maintenance Supervisor deficient practice could affect all reviewed the guidelines residents, staff and visitors. Emergency-Weekly Exercise/Monthly Load Test. The Maintenance Supervisor conducts Findings include: weekly exercise tests each Friday at 2:00pm with the monthly load Based on review of "Emergency-Weekly test on the first Friday of the each Exercise/Monthly Load Test Log" month. Documentation of the percentage of load capacity and monthly load test documentation with the minimum exhaust gas Maintenance Supervisor from 9:40 a.m. to temperature documented on the 11:15 a.m. on 04/05/11, monthly Emergency-Weekly emergency generator load testing on Exercise/Monthly Load Test Form. The Maintenance Director 01/07/11, 02/04/11 and 03/04/11 show the submits the exercise and load emergency generator ran for at least thirty test results to the Safety minutes each month but neither the Committee monthly. percentage of load capacity or minimum How the corrective action(s) exhaust gas temperature was recorded. will be monitored to ensure the deficient practice will not recur, Based on interview at the time of record i.e., what quality assurance review, the Maintenance Supervisor stated

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
and Plan of Correction identification number: 155237		A. BUILDING				
		100201	B. WING	ADDRESS, CITY, STATE, ZIP CODE	0 1/0 0/2011	
NAME OF F	PROVIDER OR SUPPLIER		I	SHELBY ST		
BETHANY VILLAGE NURSING HOME			INDIAN	IAPOLIS, IN46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
		hed to new record		program will be put into place	-	
	keeping forms fo			The Emergency-Weekly		
		e percentage of load		Exercise/Month Load Test Log is submitted to the Continuous		
	capacity was not	recorded on the new		Quality Improvement (CQI)		
	form in documenting monthly load			committee overseen by the		
	testing.			executive director. If compliant is not achieved then an action		
	3.1-19(b)			plan may be developed to ens compliance.		